Psychoanalytic Social Work, 21:19–39, 2014
Copyright © Taylor & Francis Group, LLC
ISSN: 1522-8878 print / 1522-9033 online
DOI: 10.1080/15228878.2013.865245

Routledge
Taylor & Francis Group

Putting It All Together: An Integrative Approach to Psychotherapy with Eating Disorders

F. DIANE BARTH
Private Practice, New York, New York, USA

Eating disorders are no longer considered isolated or single symptom disorders. Numerous authors have noted difficulties categorizing and treating these "refractory" disorders, and over the past three decades the number of techniques, ideas, and approaches available to address these issues has expanded exponentially. While this provides therapists with a wide range of possible interventions, it also leaves open the question of how to choose from this wide field of possibilities. In this discussion I offer some ideas about bringing together disparate, even contradictory, therapeutic ideas and techniques into a relatively cohesive frame which will enhance the work of any therapist with clients with eating disorders.

KEYWORDS eating disorders, integrative techniques, integrative theory, clinical practice

INTRODUCTION

Jamie was a petite young woman whose tendency to dress in jeans, T-shirt, and tennis shoes made her look younger than her 30 years. A professional performance artist, she was engaging and articulate. In her first therapy session with me she talked with only a little discomfort about her history with anorexia and then bulimia. She said that for several years she had been able to control her symptoms so well that she had assumed she was cured, even though, like most of her colleagues, she would binge occasionally. As she put it, a strict diet and extensive daily exercise regimen with occasional lapses into eating orgies and purging was the norm in her business. She was concerned, however, because for several months she had been bingeing and

Address correspondence to F. Diane Barth, 102 W. 85th Street, New York, NY 10024, USA. E-mail: fdbarth@gmail.com

throwing up more and more often. Furthermore, she was having thoughts about cutting herself, something she had done throughout her teens, but had not done for years. Although so far she had been able to refrain from acting on these thoughts, she was afraid she might not be able to maintain the control.

"I don't understand," she said. "I'm having a wonderful life, doing what I love; and I have a terrific boyfriend who I adore, and who wants to marry me and have a family with me. Why would I want to destroy all of this?"

This is not an uncommon question for people with eating disorders. It can be presented with sadness, desperation, or with self-criticism, anger and frustration. But what does this question mean? And how can a clinician turn it into the beginning of a useful therapy for each client who asks it? When I began working with clients with eating disorders more than 30 years ago, there was limited literature to either explain or describe how one might work with these symptoms, which were increasing at an alarming rate. What was available generally fell into one of three major theoretical groupings: classical drive/conflict (Breuer & Freud, 1895/1957), object relations (Bruch, 1979, 1980), and feminist (Orbach, 1979). Today we have an expanded understanding of these disorders, which includes not only new knowledge about attachment, affect regulation, impulse control, and addictions, but also the realization that there are several different eating disorder configurations and significant comorbidity with other diagnostic categories (American Psychiatric Association, 2013). The number of techniques, ideas, and approaches available to address these issues has also expanded exponentially, so that therapists have a much wider range of interventions available than we did in the early 1980s. As a psychoanalyst, I am always interested in understanding possible meanings of any behavior; but my experience with my own clients as well as with supervisees and colleagues who consult with me dovetails with research showing that psychodynamic exploration and understanding alone is seldom enough to bring about change in these behaviors in many symptomatic individuals (e.g., Connors, 2006; Johnson, 1999; Kaplan & Garfinkel, 1999; Novick & Novick, 1998; Roth & Fonagy, 1996; Zerbe, 2008).

I have discussed some of these issues elsewhere (Barth, 2014b). I have noticed over the years that many clients with these symptoms have highly developed verbal abilities and apparent capacity for insight, but that their apparent self-knowledge does not help them manage their affects, a problem that Krystal (1988) links with alexithymia. Recent research (Castanier & Le Scanff, 2009) has confirmed that alexithymia makes it difficult to manage affects and leads to a variety of impulsive and addictive behaviors. Evidence-based insistence on particular approaches notwithstanding (see, for example, Barth, 2014b; Shedler, 2010), it is frequently not clear what techniques would be best to use, when, and with whom. Because much has been written about various ways of understanding eating disorders from a

psychodynamic perspective, I will not go into detail about this aspect of the symptoms in this article. Instead, I will focus on how a psychodynamically oriented clinician can integrate other approaches to help ameliorate the problem of false or inadequate use of insight when working with these clients. I would suggest that such tactics might also be useful in reverse; that is, clinicians working from cognitive and behavioral perspectives, for example, might find some help in this article for integrating some psychodynamic understanding into their work.

Although sometimes seen as lacking in theoretical clarity (see Boulanger, 2011), integrative practices are becoming more common not only among mental health practitioners, but also in a wide range of medical practices (e.g., see Connors, 2011; Fawcett, 1997; Gitterman & Germain, 2008; Frank, 1999; Wachtel, 1997). In the narrower field of practice with clients with eating disorders, integrative work has become the pragmatic approach of choice (Barth, 2003; Connors, 1994, 2006; Johnson, 1999; Kaplan & Garfinkel, 1999; Zerbe, 2008). In part because of a lack of an organized theory of integration, clinicians often feel that they are floating on a raft of their own making when they choose to bring together different theoretical and practical approaches to the work. In this article I offer some ideas about psychodynamically meaningful integrative work with this population in the hope that these thoughts will contribute to a more organized, theoretically and technically cohesive approach to integrative work with these symptoms.

To begin, as I noted earlier, eating disorders are most often not isolated or single-symptom disorders. Numerous authors have described difficulties categorizing and treating the problems, in part because of the wide range of symptomatology and comorbidity with other disorders and in part because of a high relapse and chronicity rate (Johnson, 1999; Kaplan & Garfinkel, 1999; Zerbe, 2008). Recognition of the complexity of these disorders has also affected the *Diagnostic and Statistical Manual of Mental Disorders'* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) categories and descriptions of eating and feeding disorders, including classifying binge eating as a disorder, revising and making more complex some of the diagnostic criteria for anorexia nervosa and bulimia nervosa, and including pica, rumination, and avoidant/restrictive food intake disorder within this classification. An integrative perspective is extremely useful in that it expands both available tools for working with different aspects of any client's struggles, and provides a larger therapeutic pool upon which a client can draw for assistance. Research (Connors, 2006; Johnson, 1999; Kaplan & Garfinkel, 1999; Novick & Novick, 1998; Roth & Fonagy, 1996; Zerbe, 2008) has shown that a mixture of symptom-focused, cognitive behavioral, supportive, insight-oriented, affect-regulatory, medical, and psychopharmacological interventions is often more helpful with this population than a single, linear approach. Furthermore, much of this same research has shown that work with a team in which different specialties are provided by different therapists—e.g.,

family, group and individual, medical and psychopharmacological, cognitive behavioral and insight-oriented—can also be beneficial (see also Novick & Novick, 2005). In this article we will therefore look at two distinct but often intercepting concepts of integrative work: the use of multiple theories and techniques by a single clinician in her work with a specific client and also the use of a structured (whether formally or informally) group of professionals with different specialties working together as an integrative team in the therapy of a single client. An extended clinical example will illustrate some of the ways in which this approach can unfold.

Even though psychodynamic exploration alone is seldom enough to produce significant change in disordered eating (e.g., Barth, 1998, 2008; Connors, 2006; Johnson, 1999; Kaplan & Garfinkel, 1999; Rabinor, 1991; Zerbe, 2008), there is evidence that psychodynamic understanding can still be a powerful tool for helping a clinician choose appropriate interventions, and for enhancing the effectiveness of other approaches (Bromberg, 1994; Connors, 1994, 2006; Frank, 1999; Leichsenring & Rabung, 2008; Mishna, Van Wert, & Asakura, 2013; Wachtel, 1997). Using an integrative practice in which symptoms and affect regulation are addressed within the context of understanding and accepting multiple underlying meanings can be particularly effective in dealing with the range of symptoms, personality styles, and family dynamics that manifest with these symptoms (Connors, 2006; Novick & Novick, 2005; Zerbe, 2008). As both a social worker and a psychoanalyst, I have learned that it is not only not antithetical to provide concrete services and focus on psychodynamics at the same time, but that these two different aspects of the human experience are deeply and inextricably linked with each other. They inform each other, enhance each other, and simultaneously explain each other.

My years of teaching and supervising therapists have led me to believe that many, if not most, clinicians bring integrative practices into the work on a daily basis, although we often feel that we have done so at the cost of one or the other of the theories to which we adhere. Yet clinical work has a long history of integration. Not only Freud, but many of his followers, were integrators. Freud fed and collected money for analysands. Kanter (2004) notes that Winnicott integrated social work concepts learned from his wife Clare into his analytic thinking. Wallerstein (2000) notes that experienced clinicians are almost always integrators, sometimes without realizing it. In the field of eating disorders, integration began with the earliest reported psychoanalytic case. Breuer and Freud (1895) had from the beginning thought that Breuer's patient Anna O., whose symptoms included anorexia nervosa, suffered from both a hysterical and traumatic neurosis. In her seminal work on the disorder, Bruch (1979) recognized that fears about sexuality were often present in adolescent girls suffering from anorexia nervosa, but added that "anorexia nervosa becomes manifest at the time of a developmental crisis, most often when an adolescent girl is confronted with the task of

becoming self-reliant and independent, and of growing beyond the immediate family" (Bruch, 1980, p. 169). Attempting to explain why these anxieties were translated into self-starvation, she outlined an object relations (and presaged attachment, relational and neuropsychological) explanation that the illness is a response to early problems in the development of a healthy sense of self separate from parental authority. During this same period, Levenkron (1978) also noted that these youngsters are trapped by a need to be good girls and integrated a psychodynamic approach with techniques for dealing with the symptoms and the family dynamics that might be causative. Recognizing that cultural factors and stereotypes were also at work, Orbach (1979) developed an approach (and a treatment and training institute) which gave priority to feminist issues inherent in body image, compulsive eating, and bulimia.

Today most of us are influenced by a range of ideas that we may not even realize are aspects of different theories. One example is mindfulness practice, which derives from Buddhist tradition but has been integrated into dialectical behavioral, cognitive behavioral, psychodynamic, and movement therapies and today is almost a stand-alone part of popular culture. I would suggest that today almost any intervention, whether a psychoanalytic interpretation, a cognitive behavioral exercise, a mindfulness technique, a self-soothing strategy, or a prescription for medication—or anything else in our deep basket of contemporary psychotherapeutic possibilities—is, in and of itself, an integration. Because it is not always simple to seamlessly integrate different approaches, it behooves those of us with experience to clarify and illustrate how we choose what to do and when. With this task in mind, I therefore offer several specific incidents from my long-term work with Jamie, the client I described at the beginning of this article. I am not suggesting that one apply these specific integrative practices to all work with all clients. With the presence of many different types of eating disorders and factors involved—including biological, environmental, historical, psychological, and characterological—and because there are so many effective forms of therapy, therapists are constantly faced with the task of deciding how best to proceed with any client at any given time. In this presentation of my efforts to draw from different theories with a specific client in response to her needs at given times in the work, I hope to illustrate not only several components of an integrative approach, but also a key concept of the work: integration is an ongoing *process*. Current research has underscored the importance of therapy as a place where clients can put unformulated or "unthought known" (Bollas, 1989) material into words (e.g., Bromberg, 1994; Siegel, 1999; Rustin, 2013; Schore, 2003). It is not a great leap to suggest that the same is true for clinicians.

As Mitchell (1998) points out, sometimes a clinician does not know until after the fact why a certain intervention seemed to make sense; but it is extremely important that we try to understand it after the fact, even if we

could not explain it to ourselves at the moment. Only in this way can we determine whether our actions are based on a client's needs or our own countertransference enactments. Loewald (1989) writes that confusion and disorganization are necessary parts of learning. Bromberg (1994) suggests that by asking clients to put experience into words, a therapist is not only asking what that experience means, but is also establishing a relational interaction that allows us to understand that meaning. The same is true when a clinician attempts to understand his own unarticulated reasons for any action. Let us return to Jamie and the question she asked at the beginning of her therapy: Why would she binge and purge at a time in her life when everything seemed so good? (A note about confidentiality: In this presentation, as is true any time I write or talk about a client, I have significantly altered names and other identifying information to protect the client and her or his family's privacy.)

CLINICAL ILLUSTRATION

Questions like the one that Jamie asked at the beginning of her therapy (e.g., "I'm having a wonderful life. Why would I want to destroy all of this?") are incredibly tempting. I think clinicians may be forgiven for wanting to use it as a jumping board to educate a client about the underlying meanings of the eating symptoms. But I would suggest instead that it is a moment in which we can begin to explore what a client is able to put into words about her internal and external worlds. It is an opportunity to begin an assessment of what and how she thinks about herself and what techniques she has already used to address the behaviors. This information will help a clinician decide what steps to take initially—what form of therapeutic intervention might be most appropriate and effective in this early stage of therapy.

As I listened to Jamie, I heard that she was interested in understanding her behaviors and also had some positive history using behavioral techniques to change self-destructive patterns. It seemed to me that a two-pronged approach, such as that described by Connors (2006, 2011) that is focused on self-regulation and self-initiated behavior change, would probably be the most effective way to start. I therefore began to think about how I might best begin to help her understand what her symptoms could mean and at the same time offer her some techniques for managing the affects that were threatening to overwhelm her, which she was currently attempting to regulate with her eating behaviors. I said that I believed that her symptoms had some unconscious or at least unrecognized meanings, but that they were also signs of her attempts to manage feelings that might be related to these meanings. I said that we would begin by working on finding some ways for her to calm herself down when she was feeling anxious, and to make herself feel better when she was feeling bad. We would also start

trying to talk about some of the reasons that she might be feeling these ways. "We'll do it this way," I said, "because as we talk about what might be upsetting you, you might start to get even more upset; and then you'll need more tools for managing the feelings in order not to turn around and binge. But I have also learned that putting things into words to another person, things that you might be concerned about even saying out loud in your own head, can eventually also make those thoughts and feelings more manageable."

Jamie nodded and said that she knew from previous therapy that her symptoms had originated in feelings of loss and anger that she didn't know how to handle. Like many people with eating disorders, Jamie was extremely articulate about the meanings of her symptoms, but she had no idea why they were coming up now. It is often difficult to know where to intervene in the early days of therapy. Integrating the social work dictum to "start where the client is" and Kohut's (1977) emphasis on the importance of staying near to a client's conscious experience, I encouraged her to tell me more about what she did know about what these behaviors meant in her own life. She said that she had always been a picky eater, but that starting at about the age of six she had become so restrictive that her pediatrician insisted that her mother take her to see a child therapist. Jamie had no memories of the therapy, but her mother had told her that the therapist said her behavior was related to the sudden and extremely ugly divorce that occurred when Jamie was about five years old. Jamie had always found therapy helpful. "I think that my first therapist, the one I had when I was six, made my mother allow me to have contact with my dad again," she told me. She felt safer and more secure once she began to see her father on a regular basis. The eating disorder diminished. And therapists had become established as benevolent and protective.

DETAILED INQUIRY AND ONGOING PROCESS: ORGANIZING PRINCIPLES FOR INTEGRATION

It seemed clear from this much of Jamie's history that her eating disorder was a way of coping with the loss of a secure attachment base, and the original "cure" of the behavior was the return of her primary secure attachment figure into her life. Research has linked attachment issues, eating disorders, and difficulties regulating and managing affect (Connors, 1994, 2006, 2011; Johnson, 1999; Novick & Novick, 2005); but there is also a significant amount of data that makes it clear that it is a mistake to conclude that therefore all individuals with eating disorders have had poor or traumatic attachment experiences. As noted in Dozier, Stovall-McClough, and Albus (2010), "It simply does not make sense to think of patients in terms of a single, mutually exclusive attachment classifications [sic] that presumably remain stable within the clinical situation" (pp. 584–585). Rather than focus on specific

attachment styles or assumptions about history, when a client reveals an eating disorder it is more helpful to think about the specifics of an individual's current attachment behavior or "attachment state of mind" (Dozier et al., 2010). Safran and Muran (2000) suggest that a therapist look at a "patient's characteristic style of construing and acting as it unfolds in the present" (p. 86), within the context of an overall picture.

In my own work, I have found it more productive to think in terms of two organizing principles: one based on Sullivan's (1953) ideas about "detailed inquiry" and the other based on the concept of process. Both of these principles help clients live with confusion and begin to explore their experience from the inside. Let us turn first to the detailed inquiry.

Kanter (2013) writes the following:

> Sullivan's concept of the "detailed inquiry" in the "psychiatric interview" is not far afield from the social history approach implicit in social work assessment. Within the context of conversational, yet organized, inquiry, the therapist or social worker gathers information about all aspects of a client's life: current life circumstances (living situation, family life, employment, friendships, activities, etc.), past history (parents, siblings, geography, socioeconomic status, education, employment history, losses, separations), life trajectory, health, and so on. In doing so, the therapist quietly notes patterns, gaps and inconsistencies as information unfolds. Much of this information is needed in assembling the "ecomap" and genogram which are common tools in social work practice. From a technical standpoint, there is a clear distinction between the active role of a therapist or social worker guiding the detailed inquiry and the analyst who passively listens to the free associations of the analysand. (pp. 16–17)

I have borrowed from Sullivan's original idea in my own work, using it to help clients pay close attention to the tiny details of their daily lives, many of which they tend to ignore or write off as unimportant. Not only does a detailed inquiry help clients begin to formulate unarticulated or previously unrecognized or dissociated material, as described by Bromberg (1994), or what Bollas (1989) calls the "unthought known"; it also provides an integrative umbrella for the work itself. Clients often feel both secure and comforted by the experience that a therapist is trying to understand them. For instance, as I encouraged Jamie to tell me about the tiny details of her daily life, I began to hear themes of anxiety about attachment issues. It seemed to me that her binging, purging, and thoughts of cutting often occurred at moments that she was struggling with feelings about her changing relationship with her fiancé—feelings that she was unable to articulate or to manage without the aid of her symptoms.

The concept of process is often directly related to any detailed inquiry. Process, as I am using it, refers to the idea that experience is not static, but

instead consists of an ongoing unfolding or development over time. How we feel and think about any experience is colored by changes in other aspects of our lives—interactions with others, changes in our psyche and our intellect as we go through the normal phases of development, even shifts in weather, time of day, and our current state of mind. A detailed inquiry, or any other intense conversation with another person, is part of the change process. Research has suggested that simply saying things out loud to someone else can actually change the messages our brains send to us (e.g., Rustin, 2013; Schore, 2003; Siegel, 1999).

RECOGNIZING AND WORKING WITH CAUSES OR TRIGGERS OF SYMPTOMS

One day shortly after we began working together, Jamie started her session with the comment that her eating had been worse than ever for the past few days. I asked her if she had any idea what might have triggered the binge, and she shook her head. While ultimately it can be important for a client to begin to look at the triggers of any eating symptoms, it is not an easy process. I have found that it is often impeded by feelings of shame, anxiety, and fear of being overwhelmed. While it is not uncommon to ask clients to keep a food log in order to begin to increase their awareness of behaviors that are often part of a dissociated experience, for some clients logs actually increase the painful feelings. They may, for example, feel ashamed about what or how they eat, and reporting it to a therapist exacerbates the shame; yet they cannot always explain their reluctance, and they feel equally ashamed of their inability to carry out what seems to be a simple task. Paradoxically, in many instances over the years I have found that when a client is able to keep a food log, he or she is often already less symptomatic than in the early stages of our work. However, I still in general ask clients to try to pay attention, either before, during, or after a binge episode, to what they were thinking about and doing (not usually what they were feeling, because that can be too disruptive or upsetting or, frequently, simply unavailable) in the hours and moments before they began the behavior.

By explaining and consistently reinforcing the importance of these small steps toward understanding and changing these behaviors, I introduce the idea of detailed inquiry and the importance of process. Change often takes time and occurs in a nonlinear fashion, which can be difficult for clients to accept. Understanding what triggers an episode is an excellent example of both process and detailed inquiry. I asked Jamie if she could remember when she first realized that she was either on a binge or was going to binge. She thought for a moment. “I’m not sure,” she said. “But I know my binges are often because I’m angry… and I wasn’t feeling angry at all last week.” I asked her how she knew this about her binges. “It’s what my last

therapist and I figured out," she said. "Do you actually feel angry feelings?" I asked. She looked puzzled, and then said, "No ... at least not when I start to binge. Sometimes afterwards I would feel it, especially when my therapist pointed it out to me." I said, "That's fine. It's very likely that the binges actually help you manage the feelings so that you don't have to face them directly." I spelled this out because I wanted her to understand that the symptoms actually provided a service for her and that I did not expect her to feel the feelings. I also suspected that anger was not the only reason she binged and wanted to leave open the possibility of other affective triggers. I asked if she would be willing to follow a couple of suggestions to see if we could figure out what set off this particular binge cycle. She nodded. I then asked if she could remember when she was not bingeing the previous week.

She knew she had not binged on Thursday, because she had taken a yoga class Thursday night and did not remember feeling bad about her body. I said, "You don't feel okay about it when you're in the middle of a binge?"

"No, I hate the fat rolls around my belly."

Because Jamie was so thin that there were no possible rolls of fat anywhere on her body, and because I have found that eating disorder clients often take silence after such a remark as confirmation of the body-dysmorphic self-assessment, I responded to this statement with a light question. But I did not want to get sidetracked by a lengthy discussion of her distorted body image, which I have found to be more accessible to meaningful discussion later in the therapeutic process. So I simply and gently asked if she really thought that she had rolls of fat anywhere on her body.

She looked sheepish. "I know no one else sees them ... but I can feel them. It's where my weight always goes."

"Okay we'll come back to this later," I said. "But for the moment, let's stay with the question of when this binge/purge cycle started. So Thursday after the yoga class what did you do?"

She had gone home and had her usual dinner of odds and ends, trail mix and popcorn. I asked for more details about her night, how she had slept and how she felt when she woke up. She told me that she never slept very well, and that when Hank slept over she barely got any sleep. I asked if she had any thoughts about that. "Well, my bed's small and he snores.... I usually end up sleeping on the couch." I grinned and said, "That hardly seems fair. Why don't you make him sleep on the couch?" She said that she could not wake him up enough to get him to move. Since Jamie was still presenting it as a wonderful relationship, I did not push the question, but I tucked it away as another indicator of Jamie's difficulties with self-regulation, and an indication that Jamie probably had difficulty asking others to respond to her needs. In my experience quite a number of clients with eating disorders have difficulties with sleep, frequently related to difficulties calming or soothing themselves enough to fall and/or stay asleep.

BODY AND MIND

As part of my integrative practice, I request that all clients with eating disorders have a physical checkup as part of the underpinnings of our therapeutic work. Although many of my clients do not follow through on this request in the early days of our work together, having made it part of the initial agreement makes it easier to bring it back into the room as soon as I become concerned about weight loss, electrolyte imbalance, and other health issues. This is part of what I call my virtual team-building, which can include a physician, psychopharmacologist, nutritionist, Dialectical Behavioral Therapy (DBT) or Cognitive Behavioral Therapy (CBT) therapist, a client's family, and Pilates and yoga teachers, massage therapists, physical coaches, and so on. I do not always have direct contact with the members of the team, but I view them as active participants in the therapy, which in many ways is focused on finding ways to self-regulate. Frank (2007) has described the importance of learning to self-regulate in a variety of different ways to manage bipolar disorders. I have found many of her suggestions helpful as well for clients with eating issues, and have found that the virtual teams are often one of the most useful tools in building such skills. I often ask clients about their interactions with the other team members and try to integrate these discussions in the process of both understanding and setting limits on problematic behavior. In many instances, this makes it easier to manage some of the common physical manifestations of difficulties with self-regulation that appear in clients with eating disorders. Sleep problems are one group of these difficulties, which clients often do not realize are linked to their eating disorders. Often, however, clients are resistant to exploring these symptoms, even though they are problematic, until later in the work, when a modicum of trust has been achieved and a working relationship has been established. This is how it worked with Jamie.

In our initial discussions, Jamie acknowledged that sleep had always been somewhat elusive, but she did not think it was worth the time or energy to try to address it in therapy. "It's been a problem forever. I manage," she said. As her wedding day approached, however, she showed increasing signs not only of stress, but also of exhaustion. My understanding of her alternating fears of losing her autonomy and of losing her secure base, which I always couched within the context of her loving attachment to Hank, seemed to be helpful in many ways; but she was still having difficulty soothing herself both when these anxieties emerged and when she had to deal with the normal stressors related to an upcoming wedding. At this point she told me that she was having more than her usual troubles sleeping and was "eating" over-the-counter sleep medications, but they were not helping much. I asked what her physician said about the problem. Jamie had not spoken to her about it, but she had had extensive conversations with a beloved dance teacher, who had encouraged her to drink chamomile tea before bedtime.

"Have you tried it?" I asked. She shook her head. I explored why she had not, and discovered that she, like many of my clients with eating symptoms, had no nighttime routine. She was also secretly afraid that it would not work and that she would then be disappointed in this teacher. In this case, I set limits gently by telling Jamie that I totally understood and agreed with her need for sleep, but that I did not love the idea that she was taking the sleep meds indiscriminately. She nodded, and I added that I understood that she needed something to help. I also explained that sleep problems are not at all uncommon with people who have eating disorders, and said that I had a couple of ideas which might help her get to sleep without medication. If they did not work, I said, we could consider prescription meds in the short term, and more extensive medical testing in the long term. Bringing in the psychodynamic of her fear of feeling hopeful, I said that I understood that she might worry that my solution would not work, either. If it didn't we would talk about how she felt about it and what it meant to her. But, I said, I thought it might be worth trying.

Jamie's sleep issues were, like those of many clients, tied to her general difficulties with self-regulation. Jamie had difficulties following through on daily routines that might calm her and help her gradually fall asleep. She believed that she should simply be able to get into bed and sleep, and if this did not happen, she became panicky. Not surprisingly, as soon as she began to get anxious, it became impossible for her to sleep. After doing a detailed inquiry into her sleep preparations, I offered techniques directed toward helping her develop regular routines for preparing herself for bed and for sleep. I helped Jamie begin to see the significance of other such routines as part of her daily life. For instance, Jamie frequently failed to take her contact lenses out of her eyes in a timely way, which meant that she suffered from irritated eyes. We worked on helping her develop a routine for removing her lenses, which impacted not only her physical comfort but, to her surprise, her ability to sleep.

I asked Jamie to tell me about the morning, after she woke up. Hank had left early for the gym, and Jamie had felt bad that she was not going to work out as well. She could not decide what to wear, because she and Hank were going out to dinner, and she wanted to look pretty for him, but she did not want to be too dressed up at rehearsal. She then remembered that she had not eaten all day, because she wanted to be able to eat whatever she wanted at dinner; but she was starving when they got to the restaurant, and she began eating bread. "After my third slice of bread and olive oil, I knew I was going to throw up, so I figured what the heck, I'll just binge."

I told Jamie that she had just described one common binge trigger. Fairburn (1995) offers a clear explanation of how restrictive eating leads to bingeing. Educating clients to this idea is important, and far from easy. I find myself repeating it multiple times, but the idea generally only takes hold years into the therapy. Nonetheless, it does eventually take hold. Jamie,

who I've now been seeing for several years, recently told me that she had just never believed me. But since she stopped restricting, her weight has stabilized—no matter what she eats, it never fluctuates more than five pounds in any direction. "And without dieting or throwing up!" At the time, however, I simply put this piece of information out into the air, and then asked her to tell me more about the evening. "It was sweet. Hank started talking about our honeymoon." I asked her if she could tell me specifically what he had said. She nodded. "I don't know what's the matter with me. He was great! He kept trying to get me to talk about what I wanted to do. And I just couldn't. He was being so loving. And I ... I don't know... there was the bread ... and I knew I was on a binge. Afterwards we went home and he wanted to have sex ... I didn't want him to touch me ... I knew he'd feel my stomach and be grossed out ... even though he says he loves my belly... says he's never grossed out by my body ... so I went into the bathroom to throw up ...."

It is seldom simple to decide what thread to pull from the rich tangle that a client like Jamie presents. For example, should we talk more about the idea that her going without food all day had been a trigger for her binge? Should I try to get more concrete information about the foods she was eating? Should I push into the psychodynamic issues, of which there were many? Jamie's bingeing and purging, as well as her thoughts about cutting herself, I had discovered, had emerged at about the same time as she and Hank had begun talking about marriage.

ATTACHMENT AND AFFECT MANAGEMENT

Fonagy (2002), Schore (2003), Siegel (1999) and other authors have found that attachment and affect regulation are deeply linked. For example, secure attachment provides calming, soothing, and regulating experiences that are gradually internalized, to become techniques for self-soothing and self-calming. Winnicott's (1965) holding environment, Kohut's (1977) self-selfobject relationship, and contemporary relational and attachment explanations, like Bromberg's (2001), of the interplay of language, meaning, and the therapeutic relationship, all capture some of the non-interpretive aspects of even the most traditional psychoanalytic work. Wachtel (1997) has noted that the other side of the coin is also true: sometimes active, directive, and/or structured techniques like cognitive interventions, education, nutritional advice, and limit setting create a safe haven, a holding environment, and even an interpretive insight.

Eating disorders are an extremely effective way of calming the self. I have found that offering simple suggestions for self-soothing—such as going for a walk, listening to music, taking a bubble bath, calling a friend, watching a stupid TV show—promotes these calming activities, provides something concrete for internalization, and offers an opportunity for exploration of a

variety of psychodynamic issues. Sometimes these suggestions are followed; but, as Mitchell (1993) points out, when these suggestions fail, when a client "forgets" to do an exercise or to carry out a practical solution, it becomes grist for the therapeutic discussion. In Jamie's case, her inability (or unwillingness) to carry out some of the suggestions I made became material through which we were able to articulate and understand her need to "do it herself" and her fear of becoming dependent. "What if you aren't there the next time I need you?" she eventually was able to articulate. "What happens if you disappoint me?" As we explored these worries, we also explored her fear of hoping that things could get better. "I'd rather be prepared for the worst," she said, "than be blindsided by something bad happening that I wasn't expecting."

Detailed inquiry into concrete experience can provide both mirroring and mentalization and gradually lead to a capacity to be self-reflective, which in turn can lead to a more integrated experience of living with and managing feelings (Fonagy, 2002) and contributes to attachment security. Damasio (1999), Siegel (1999), and Schore (2003) describe findings that talk therapy, which brings an opportunity for a new attachment experience and growing self-awareness, builds new neural pathways that open up the possibility for new relationships and new ways of managing and processing feelings. Paradoxically, however, talking about eating behavior often also stirs up ambivalence and anxiety in clients. Hope is a crucial ingredient for change. It helps us do the difficult work of trying to get better, of letting go (very slowly) of old protective, but not useful, habits; and it allows us to take risks as we move forward in therapy. It also makes it possible to manage hard feelings and painful situations in the present. Yet when a client is afraid to hope, a therapist cannot help by insisting that they feel more optimistic. What appears to be far more useful is for a clinician to try to maintain his or her own sense of the possibility of change while also recognizing a client's sense of doubt. In those moments a clinician recognizes both the dialectics of all experience (see, for example, Davies, 1999) and simultaneously helps a client manage his or her painful emotions through holding, containing, and digesting (see Ogden, 2005).

AFFECTS AND BOUNDARIES

While it is often tempting to encourage clients to "get in touch with" and learn to manage unprocessed affects that appear to be behind symptoms, an integrative approach takes into account that this process is not nearly as simple as was once believed (see, for example, Barth, 1998; Bromberg, 2001; Davies, 1999, 2006). One of the key difficulties for many clients with symptoms of difficulty with impulse control and affect management, such as eating disorders, addictions, and some compulsive behaviors, is that they also have difficulties with boundaries. Gabbard and Lester (1995) have extensively

explored the importance of respecting clients' boundaries in the therapeutic process; but sometimes the line between protecting boundaries and opening up affects is not totally clear. As Bollas (1989) notes, some clients do not know that there is a difference between internal and external. In these cases, intrusions into an internal space may be extremely subtle and not recognized by either client or clinician. I have found that the first indicator of this kind of breach can be an increase in symptomatology after a session. Both sets of dynamics may actually be playing out simultaneously. For an integrative clinician, it can be useful therefore to bring both aspects of experience into the therapeutic dialogue; that is, to articulate to a client that, while it is important to find ways to talk and think about his or her feelings, it is equally important to recognize and respect his or her boundaries. This is how it worked with Jamie. For some time, I suspected that she was struggling with ambivalence or anxiety about getting married, but the closest we were able to get to the subject was an intellectual and detached discussion of her fears of having her early experience of loss and abandonment by the man she loved (her father) repeated, something she told me she had learned in a previous therapy. As soon as she put it into words, she immediately "reassured" me that Hank would never do anything like that. I decided to stay with the detailed inquiry for the moment, and to see if it helped me find an end of a thread that I could pull from the tangle. I asked her to tell me about throwing up. How did she do it? Did she use a finger, a toothbrush, medicine, or what? And did she do something to keep Hank from hearing? How did she feel afterward? And what happened?

I could see that my questions were making Jamie uncomfortable, and I commented that before she tried to answer my questions, I wondered if she could tell me what she was feeling. She said that she was embarrassed. I asked if she could tell me more about the embarrassed feeling, and she said that she was afraid I would think she was "really sick," but that she would try if I thought it was important. I said to her that I thought it might be helpful at some point for her to share the information, but that I thought it was even more important to pay attention to what her feelings were communicating to us. "Do you think you'd like to get to know me a little better before you share such private information with me?" I asked. She nodded.

Addressing both the boundary question and her fear that I would see her as sick, I told her that I had great respect for boundaries and that I thought that eating disorders were sometimes adaptive, creative ways of creating boundaries in situations where they did not seem "okay." I said that it might be that in order to overcome the symptoms she might need to learn to respect her own boundaries and set limits that helped her protect her privacy. Jamie said that she did not like setting limits, because they hurt other people. "Is that sometimes a problem with Hank?" I asked. She began to deny that she had any difficulty with boundaries with Hank. It was nearing the end of the session. Accepting her response at face value for the moment,

I said that if she would like, she could try something the next time she was feeling like bingeing. “Even if you don’t know what’s triggering it,” I said, “try doing something soothing for yourself. Something that gives you a sense of well-being and also a feeling of gentle privacy.” She wasn’t sure what I was suggesting, so I gave her a couple of ideas: take a warm bubble bath, or go for a walk and listen to some soothing music.

Over time we began to see that her eating symptoms might be at least in part related to a combination of difficulties setting appropriate boundaries (partly because of her fear of loss and abandonment) and of soothing herself when she felt intruded upon or overwhelmed by the demands of others. I have found that a discussion of boundaries is a perfect meeting place of manifest and latent material, or to put it another way, boundaries can be a concrete and manageable manifestation of a wide range of intimacy issues. Starting with observing boundaries, I find that I have been able to move with clients into fears of being hurt, inability to say “no,” concerns about anger (their own and that of others)and discomforts with their own needs, among other significant psychodynamic issues.

ALEXITHYMIA

One important component of eating disorders is that they are often attempts—albeit ultimately maladaptive—to adapt to intolerable or impossible situations (Barth, 2003; Connors, 2006). Many clients with these disorders suffer from what has been called alexithymia (Barth, 1998, 2008; Krueger, 1997; Krystal, 1988; McDougall, 1989; Schore, 2003; Taylor, Bagby, & Parker, 1997), or an inability to use these thoughts or words to process emotions. In a concise summary of alexithymia, McClintock Greenberg (2009) describes alexithymia as involving “difficulties identifying and describing feelings, differentiating between emotional and physical sensations, and exhibiting a concrete and externally oriented cognitive style” (p. 136). It can be hard to recognize alexithymia in people who struggle with eating disorders, because many of them are extremely bright and articulate and speak freely of their feelings and both the current context and historical explanations for them, so it is often not obvious that their words are not helping them process emotions.

The paradox of intelligent, insightful people who cannot use language to manage their feelings can be confusing not only for their therapists, but for families, friends, colleagues, and clients themselves. A relationship with a therapist who is interested in finding ways to talk and think about feelings can stir both hope and anxiety in clients with these symptoms. A therapist’s ability to understand and communicate the role of the symptoms in managing intolerable or overwhelming feelings can help make the process feel

less dangerous. Clients may want to give up their symptoms, but without other tools for self-soothing and self-regulating, they are not really ready or able to do so. One of the ways that I have found to help with this process is to look for other, less threatening areas of self-soothing on which we can work. In this process, I combine understanding, accepting, and explaining the meanings of behavior with limit setting.

Many clients with eating disorders suffer from other impulse control and/or affective disorders, including the binge drinking indulged in by many adolescents today to drug and/or alcohol addiction, risky sexual behaviors, cutting, face-picking and other self-harming activities, compulsive shopping and gambling, among other things. Therapists often have to walk a fine line between nonjudgmentally accepting these behaviors in order to make a client feel safe enough to be willing to talk about them, and helping a client begin to protect herself from the consequences. There are no simple solutions to this dilemma; but an integrative stance is particularly useful here. I tend to start out with an empathic, accepting, and interested attitude, but I also look for moments when I can engage a client's ego in self-protection. In cases of extreme alexithymia or dissociation from the body, situations in which masochism and self-hatred overrule healthy self-regard, and when the behaviors are what Klein (1973) called "active reversal of a passive position," as well as when a client has no alternative tools for managing intolerable feelings, I consider that the therapist must take the position of an external ego, or a variation of what Kohut (1977) called a selfobject—someone outside the self who actively provides functions that the person cannot provide for himself or herself.

When in this situation, I explain my position: "I know that right now you cannot take care of this; but my job is to try to find some ways to help you be able to," I might say as I request that a client attend Alcoholics Anonymous (AA) or take some sort of protective measures when having sex. This is one of the times that working with a team is an important part of an integrative process. Unfortunately, there is not space in a single article to elaborate fully on this aspect of integration, but to put it most succinctly, members of a team can supplement and complement one another's work. Working with one another and avoiding the splitting that sometimes occurs in this work (e.g., when an individual therapist blames parents and a family therapist blames an individual client for the difficulties, or psychiatrist and therapist are not respectful of each other's contributions), a team can be a powerful integrative tool. For example, at one point a young client insisted that her regular use of alcohol, drugs, and risky sex to "feel" were not self-destructive; but when her psychopharmacologist remarked that "therapy and medication are weaklings in comparison to the power of the drugs and alcohol," she suddenly understood that the behaviors were actually interfering with her being able to feel better.

CONCLUSION

In this article we have considered that although the growing number of approaches available for dealing with eating disorders can be somewhat confusing, they can also each enhance the productiveness of the others. Research has shown that a mixture of symptom-focused, cognitive behavioral, supportive, insight-oriented, affect-regulatory, medical, and psychopharmacological interventions is often more helpful with this population than a single, linear approach (Barth, 2003; Connors, 1994, 2006; Johnson, 1999; Kaplan & Garfinkel, 1999; Zerbe, 2008).

Moving back and forth between more structured and more exploratory interventions can also provide both a secure attachment experience and an opportunity for clients to work on what Lyons-Ruth (1991) calls "attachment-individuation"; that is, the capacity to be both connected to another person and to develop a sense of autonomy and individual identity. Furthermore, it provides a holding environment (Winnicott, 1965) in which a client can develop further in whatever areas he or she needs in order to no longer need the eating disorder symptoms to either protect or regulate himself or herself. Teaching clients to be mindful and self-reflective, and to make use of a wide range of self-soothing techniques while also exploring the meaning of known but unformulated experiences, is more than helping a client internalize a wide variety of tools and techniques for managing his or her symptoms. Integrating psychodynamic exploration and understanding with more directive and supportive techniques for self-understanding, self-soothing, and self-regulation offers clients an opportunity to grow, to change, and to move toward a healthy and meaningful future.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.

Barth, F. D. (1998). Speaking of feelings: Affects, language and psychoanalysis. *Psychoanalytic Dialogues*, *8*, 685–705.

Barth, F. D. (2003). Separate but not alone: Separation-individuation issues in college students with eating disorders. *Clinical Social Work Journal*, *31*, 139–153.

Barth, F. D. (2008). Hidden eating disorders: Attachment and affect regulation. *Clinical Social Work Journal*, *36*, 355–365.

Barth, F. D. (2014a). Eating problems and resilient populations. In A. Gitterman (Ed.), *Handbook of social work with vulnerable and resilient populations* (3rd ed.). New York, NY: Columbia University Press.

Barth, F. D. (2014b). *Integrative clinical social work practice: A contemporary perspective*. New York, NY: Springer.

Bollas, C. (1989). *The shadow of the object*. New York, NY: Columbia University Press.

Boulanger, G. (2011). Arguing with myself: Thoughts on taking an integrative approach. *Clinical Social Work Journal*, *39*, 201–203.

Bromberg, P. (1994). Speak! That I may see you: Some reflections of dissociation, reality, and psychoanalytic listening. *Psychoanalytic Dialogues*, *4*, 517–547.

Bromberg, P. (2001). *Standing in the spaces: Essays on clinical process, trauma and dissociation*. London, UK: Routledge.

Bruch, H. (1979). *The golden cage*. New York, NY: Vintage Books.

Bruch, H. (1980). Preconditions for the development of anorexia nervosa. *American Journal of Psychoanalysis*, *40*, 169–172.

Breuer, J., & Freud, S. (1957). *Studies on hysteria* (J. Strachey, Ed. & Trans.). London, UK: Hogarth Press. (Original work published 1895)

Castanier, C., & Le Scanff, C. (2009). Influence de la personnalité et des dispositions émotionnelles surles conduites sportives à risques: une revue de littérature [The influence of personality and emotional style on engagement in risky sports: A review of the literature]. *Science & Motricité*, *2*, 39–78.

Connors, M. (1994). Symptom formation: An integrative self-psychological perspective. *Psychoanalytic Psychology*, *11*, 509–523.

Connors, M. (2006) *Symptom-focused dynamic psychotherapy*. Mahwah, NJ: The Analytic Press.

Connors, M. (2011). Integrative symptom-focused dynamic psychotherapy. *The Clinical Social Work Journal*, *39*, 122–131.

Damasio, A. (1999). *The feeling of what happens*. New York, NY: Harcourt, Brace.

Davies, J. M. (1999). Getting cold feet, defining "safe-enough" borders: Dissociation, multiplicity, and integration in the analyst's experience. *Psychoanalytic Quarterly*, *68*, 184–208.

Davies, J. M. (2006). The times we sizzle, and the times we sigh: The multiple erotics of arousal, anticipation and release. *Psychoanalytic Dialogues*, *16*, 665–686.

Dozier, M., Stovall-McClough, K., & Albus, K. (2010). Attachment and psychopathology in adulthood. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (2nd ed., pp. 718–744). New York, NY: Guilford Press.

Fairburn, C. G. (1995). *Overcoming binge eating*. New York, NY: Guilford Press.

Fawcett, J. (1997). Psychopharmacotherapy and psychotherapy: Treating target symptoms and learning. *Annual of Psychoanalysis*, *25*, 17–25.

Fonagy, P. (2002). The history and current status of outcome research at the Anna Freud Centre. *Psychoanalytic Study of the Child*, *57*, 27–60.

Frank, E. (2007). *Treating bipolar disorder: A clinician's guide to interpersonal and social rhythm therapy*. New York, NY: Guilford Press.

Frank, K. A. (1999). *Psychoanalytic participation: Action, interaction, and integration*. New York, NY: Routledge.

Gabbard, G., & Lester, E. (1995). *Boundaries and boundary violations in psychoanalysis*. New York, NY: Basic Books.

Gitterman, A., & Germain, C. (2008). *The life model of social work practice: Advances in theory and practice*. New York, NY: Columbia University Press.

Johnson, C. L. (1999, May). *Been there—done that: The use of clinicians with personal recovery in the treatment of eating disorders*. Paper presented at the Annual Meeting of the Academy of Eating Disorders, San Diego, CA.

Kanter, J. (2004). *Face to face with children: The life and work of Clare Winnicott*. London, UK: Karnac Books.
Kanter, J. (2013). Helping, healing and interpreting: Sullivan, the interpersonal school and clinical social work. *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community*, *27*, 273–287.
Kaplan, A. S., & Garfinkel, P. E. (1999). Difficulties in treating patients with eating disorders: A review of patient and clinician variables. *Canadian Journal of Psychiatry*, *44*, 665–670.
Klein, G.S. (1973). Is psychoanalysis relevant?. *Psychoanalysis and Contemporary Science*, *2*, 3–21.
Kohut, H. (1977). *The restoration of the self*. New York, NY: International Universities Press.
Krueger, D. (1997). Food as selfobject in eating disorder patients. *Psychoanalytic Review*, *84*, 617–630.
Krystal, H. (1988). *Integration and self-healing: Affect, trauma, and alexithymia*. Hillsdale, NJ: Analytic Press.
Leichsenring, F., & Rabung, S. (2008). Effectiveness of long-term psychodynamic psychotherapy: A meta-analysis. *Journal of the American Medical Association*, *300*, 1551–1565.
Levenkron, S. (1978). *The best little girl in the world*. Chicago, IL: Contemporary Books.
Loewald, H. (1989). *Papers on psychoanalysis*. New Haven, CT: Yale University Press.
Lyons-Ruth, K. (1991). Rapprochement or approchement: Mahler's theory reconsidered from the vantage point of recent research on early attachment relationships. *Psychoanalytic Psychology*, *8*, 1–23.
McClintock Greenberg, T. (2009). *Psychodynamic perspectives on aging and illness*. New York, NY: Springer.
McDougall, J. (1989). *Theaters of the body: A psychoanalytic approach to psychosomatic illness*. New York, NY: W.W. Norton & Co.
Mishna, F., Van Wert, M., & Asakura, K. (2013). The best kept secret in social work: Empirical support for contemporary psychodynamic social work practice. *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community*. Retrieved from http://dx.doi.org/10.1080/02650533.2013.818944
Mitchell, S. A. (1993). *Hope and dread in psychoanalysis*. New York, NY: Basic Books.
Novick, K., & Novick, J. (1998). An application of the concept of the therapeutic alliance to sadomasochistic pathology. *Journal of the American Psychoanalytic Association*, *46*, 813–846.
Novick, K., & Novick, J. (2005). *Working with parents makes therapy work*. New York, NY: Jason Aronson.
Ogden, T. H. (2005). *This art of psychoanalysis*. London, UK: Routledge.
Orbach, S. (1979). *Fat is a feminist issue*. New York, NY: Berkley Publishing.
Rabinor, J. (1991). The process of recovery from an eating disorder: Use of journal writing in the initial phase of treatment. *Psychotherapy in Private Practice*, *9*, 93–106.

Roth, A., & Fonagy, P. (1996). *What works for whom: A critical review of psychotherapy research*. New York, NY: Guilford Press.

Rustin, J. (2013). *Infant research and neuroscience at work in psychotherapy: Expanding the clinical repertoire*. New York, NY: W.W. Norton & Co.

Schore, A. N. (2003). *Affect regulation and repair of the self*. New York, NY: W.W. Norton & Co.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist*, *65*, 98–109. doi: 10.1037/a0018378

Siegel, D. J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. New York, NY; London, UK: Guilford Books.

Sullivan, H. (1953). *The interpersonal theory of psychiatry*. New York: W.W. Norton & Co.

Taylor, G. J., Bagby, R. M., & Parker, J. D. (1997). *Disorders of affect regulation: Alexithymia in medical and psychiatric illness*. Cambridge, UK: Cambridge University Press.

Wachtel, P. L. (1997). *Psychoanalysis, behavior therapy and the relational world*. Washington, DC: American Psychological Association.

Wallerstein, R. (2000). *Forty-two lives in treatment: A study of psychoanalysis and psychotherapy*. New York, NY: Other Press.

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment*. New York, NY: International Universities Press.

Zerbe, K. (2008). *Integrated treatment of eating disorders: Beyond the body betrayed*. New York, NY: W.W. Norton & Co.